Texas Department of Aging
and Disability Services

Permanency Planning Instrument for Individuals 18-21 Years of Age

Form 2261
October 2012

☐ **Initial** ☐ **Review**

Individual's Name	LA Comp. Code/LA Case No.	PP Meeting Date	Admission Date

Social Security No.	Medicaid No.	Date of Birth	Age

Facility Name	Contact Name	Area Code and Telephone No.

Parent/LAR Name	Address, City, State, ZIP Code	Area Code and Telephone No.

The summary was compiled by (all should apply):

☐ Discussions with family/legally authorized representative (LAR) ☐ Reviewing facility records
☐ Discussions with individual ☐ Observing the individual
☐ Discussions with facility staff ☐ Other (identify):

Completed by (enter name, affiliation and email address)	Area Code and Telephone No.

Section 1. Background Information

Part 1. Description of the Individual – Who is this person?

A. Describe the individual, the individual's personality characteristics, attributes, likes, dislikes, behavior and reaction to others – in non-technical terms.

B. Description of the individual's skills and abilities.

Level of intellectual disability ☐ N/A ☐ mild ☐ moderate ☐ severe ☐ profound ☐ unknown

Identify any sensory impairments ☐ vision ☐ hearing ☐ touch ☐ taste ☐ smell

Identify the individual's developmental disability: _____

What does the individual need help to do? Be specific.

Activities of Daily Living _____

Directing Service Needs _____

Community Mobility _____

C. Medical

Indicate medical conditions managed by professional health care intervention and specify the intervention type and frequency. (Attach additional pages, if necessary.)

Description of Condition: Physical Health	**Managed by Medication?**		**Managed by Health Care Intervention?**		**Describe the Intervention Type and Frequency**
	Yes	**No**	**Yes**	**No**	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

Description of Condition: Mental Health	**Managed by Medication?**		**Managed by Health Care Intervention?**		**Describe the Intervention Type and Frequency**
	Yes	**No**	**Yes**	**No**	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

Additional Information

Height	Weight	Does the individual have a feeding tube?	Is individual on a ventilator?
		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Allergies			
Other Medical Information			

Part 2. Relationships with Family and Significant Others

Relationships – Describe current and past relationships, potential for sustaining family relationships and significant prior relationships.

A.	If the individual has been living out of the family's/LAR's home, what has been their pattern of interaction with the individual (e.g., number of facility visits, home visits, outings, letters, phone calls)? Has the family or guardian participated in service planning within the facility within the past year and been available when they were needed for medical decisions, etc.?
B.	Identify the people in the individual's life, including caregivers, service providers or others, with whom he or she has (or has had) significant relationship of affection and attachment. Describe the nature, duration and continuity of each relationship.

Part 3. History Prior to Placement

A. Continuity of services and service needs when living with birth family – consider the following:

What were the family/LAR circumstances that prompted them to seek a living situation for the individual outside of the family's/LAR's home?

What kind of help/supports did the family receive in caring for the individual at home and who provided the help? What worked for the family and what did not work?

Check all applicable reasons that led to the individual's initial placement in a facility:

☐ No supports	☐ Single parent	☐ Issues of other family members
☐ Medical needs too high	☐ Individual is too big for parent to care for	☐ Facility can provide for medical needs
☐ Inadequate supports	☐ Behavioral issues	☐ Other:

B. Previous placement settings. List placement settings in order (starting with the most recent); include times living at home or in foster care.

Name of Placement	When and How Long	Type of Residence	Why Did the Individual Leave This Setting?

Section 2. Goals for the Future

Part 1. Providing Information on Options

Planning Options:

Goal	Description	Must choose one permanency goal Indicate by marking ☒
Goal 1	Bringing the individual to family/LAR home or own home with access to needed services.	☐
	Comments:	
Goal 2	Living with an Alternate Family with access to needed services.	☐
	Comments:	
Goal 3	Moving to another living arrangement determined by the individual and LAR.	☐
	Comments:	
Goal 4	Remaining in the current residence as determined by the individual and LAR.	☐
	Comments:	

Summarize the discussion with the individual and LAR, including:

- the community living options information provided to the individual and LAR;
- the community living options that were visited by the individual and LAR and those in which there is interest in visiting; and
- any issues, concerns and questions identified by the individual and LAR.

Part 2. Supports Needed to Accomplish Goal

What will the individual need to live at home, in another family-based setting or to move into another facility?	Provide Details	Is this support needed in order to accomplish the goal?
Architectural Modifications		☐ **Yes**
Behavioral Intervention		☐ **Yes**
Child Care		☐ **Yes**
Crisis Intervention		☐ **Yes**
Durable Medical Equipment		☐ **Yes**
Family-Based Alternative		☐ **Yes**
In-Home Health Services		☐ **Yes**
MH Services, Counseling		☐ **Yes**
Nighttime Supervision		☐ **Yes**
Ongoing Medical Services		☐ **Yes**
Personal Assistance: Activities of Daily Living		☐ **Yes**
Respite: In Home		☐ **Yes**
Respite: Out of Home		☐ **Yes**
Special Equipment (include Adaptive Aids)		☐ **Yes**
Specialized Therapies		☐ **Yes**
Specialized Transportation		☐ **Yes**
Other Training for the Caregiver		☐ **Yes**
Transportation		☐ **Yes**
Volunteer Advocate		☐ **Yes**

Is this individual currently in the process of enrolling in any Medicaid waiver program (i.e. HSC waiver) or is eligible for "money follows the person" funding to leave a nursing facility (i.e. CLASS, MDCP)?..... ☐ **Yes** ☐ **No** If "Yes," indicate which one:
Is this individual currently enrolled in any Medicaid waiver program (i.e. HSC waiver, CLASS, CBA, etc.)?..... ☐ **Yes** ☐ **No** If "Yes," indicate which one:

Section 3. Action Plans

		Action Plans		
Concurrent Plans	**Activities**	**Facility staff, LA staff, Relocation Specialist, Caseworker**	**Family**	**Permanency Planner**
A. While remaining in the facility	Facilitate family involvement			
	Help individual stay connected with family between visits			
B. When individual/LAR agrees with the permanency goal #1 – increase possibility of individual returning to live with family/LAR	When funding source is available for needed supports			
	While on waiting list			
C. When individual/LAR agrees with permanency goal #2 – increase possibility of individual living with another family	When funding source is available for needed supports			
	While on waiting list			
D. When individual/LAR chooses permanency goal #3 – to move to another living arrangement (i.e., facility close to family)	When funding source is available for needed supports			

Section 4. Participants

		Indicate Method of Participation (Mark with the date participation occurred.)				
Name of Individuals who Contributed to the Information Included in this Instrument	**Title or Relationship to Individual**	**Face-to-Face: In a Planning Meeting**	**Face-to-Face: In a Situation Other than Planning Meeting**	**By Telephone**	**Letter**	**Other Communication**
	Parent/Guardian					
	Parent/Guardian					
	Permanency Planner					
	Provider (if applicable)					

Parent/LAR (legally authorized representative) Information

Parent Name	Driver's License No.	Home Area Code and Telephone No.	
Parent Address (Street, Apt. No.)	City	State	ZIP Code
Parent Place of Employment		Work Area Code and Telephone No.	
Address (Street, Suite No.)	City	State	ZIP Code

Parent Name	Driver's License No.	Home Area Code and Telephone No.	
Parent Address (Street, Apt. No.)	City	State	ZIP Code
Parent Place of Employment		Work Area Code and Telephone No.	
Address (Street, Suite No.)	City	State	ZIP Code

Relative/Other Contact Name	Driver's License No.	Home Area Code and Telephone No.	
Relative/Other Contact Address (Street, Apt. No.)	City	State	ZIP Code
Relative/Other Contact Place of Employment		Work Area Code and Telephone No.	
Address (Street, Suite No.)	City	State	ZIP Code

☐ I agree to notify the local authority and the provider if any of the above information changes.

☐ I understand that this individual's placement is considered temporary and that I will be contacted to participate in permanency planning activities every six months and service planning at least once a year.

☐ I agree to make reasonable efforts to participate in the individual's life and in planning activities for the individual.

Signature – Parent _____ Date _____

Signature – Parent _____ Date _____

Signatures required for initial permanency plans.
Parent/LAR must verify accuracy of information at permanency planning reviews.